

# **Analysis of Data**

## **Executive Summary**

**Missourian Chronic Disease Baseline Telephone Survey  
Missouri Department of Health & Senior Services**

**Center for Advanced Social Research  
University of Missouri-Columbia**

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## **Executive Summary**

### **Overall Recommendations**

#### **Health Behaviors**

The campaign should communicate the real risk of developing chronic disease for those in the target market age group. This may even be incorporated in the thematic message, as MediaCross has done effectively in some of the example messages (e.g., It's Your Life. Don't Risk It.)

The target audience collectively believes it's in "good" to "very good" physical health, and already believes in the benefits of healthy eating and physical activity in preventing chronic disease. Thus, other than reinforcing these beliefs in healthy behaviors, the campaign can move immediately to defining the types and amounts of healthy eating and physical activity that will have the desired preventative effects. This will allow the target market to evaluate their current eating ("usually" healthy) and activity levels (2-3 times per week) against this "standard." The campaign should still be mindful of communicating achievable behaviors that gradually move target members toward effective levels and don't sap motivation or task-related self-efficacy. In addition to defining "what" needs to be done, the campaign should include "how" it can be done, particularly in light of time limitations of everyday life and other barriers. For example, instructions for gentler exercises may be made available to respondents for which *physical health* was a barrier to greater activity.

#### **Health Care Behaviors**

Doctors are central to the goal of keeping current in screenings. Especially given that most of the target market sees their physician only once or twice a year. In addition to working with physicians as grassroots partners, the campaign should consider submessages that encourage target market members to "Ask your doctor" about needed screenings. This, of course, should be done in way that is positively received by physicians.

A strong message concerning screenings needs to be, "Don't wait for symptoms." The costs of waiting for symptoms should be vividly communicated in loss-framed messages. The campaign should communicate screenings as scheduled events that depend on time and not symptoms (unless, of course symptoms precede scheduled screenings).

Findings show that spouses, then sons and daughters, can play important roles in pressuring target market members to keep current in their screenings. The campaign should consider incorporating messages aimed at spouses and children that urge them to take a strong role in this.

## **Sources and Media Channels**

Again, the central role and credibility of physicians is substantiated in the findings. This should be leveraged especially in the promotion of screenings. This role of physicians is central across socioeconomic groups, and especially for older adults (65+).

Television and newspapers are supported most in the data as media channels. The Internet is supported particularly for certain sociodemographic groups and would provide a reference place to get more detailed information at the user's convenience.

Doctor's offices, pharmacies, and churches were identified as primary public places where posted health information is reviewed. They should be considered for disseminating posters and also pamphlets.

Executive summaries of data section groupings, incorporated in these *Overall Recommendations*, are provided below.

### **By Data Section Groupings**

## **Description of Sample**

### **Summary**

This was a random sample of almost 400 Missourians ages 45 and older. Looking at the *Socioeconomic* section (see Table of Contents above), we see that the average age in this sample is 61, with 62% being 64 or younger and the remainder 65 or older. About 40% of respondents have a high school diploma or less and 60% have 1 year of college or more. About 56% live in small city/suburban/urban settings and 44% in smaller towns/rural areas. 90% are White, 6% are African American, and 2% identify themselves as Hispanic.

Education-levels were distributed fairly evenly across gender, race, and size of community. Gender was also fairly evenly distributed across race, with a relatively higher percentage of men living in rural settings and women in urban settings. Relatively higher percentages of Non-Whites lived in urban settings.

Looking at the *Insurance* section, 92.7% of respondents reported having health insurance, with the most common type being private or employer-offered followed by Medicare.

## **Health Status, Health Behaviors, Effect of Healthy Behaviors**

This section summarizes and makes recommendations based on data in the sections of *Self-reported health status, Physical activity, Eating, Smoking, and Control*. These data shed light on the health behaviors (exercise, healthy eating, smoking) of Missourians ages 45 and older. They also shed light on their view of the role of exercise and healthy eating in preventing chronic disease.

## Summary

**Self-reported health status.** Respondents in this survey sample generally feel their health status is “good” to “very good,” including those both at and over as well as under 65 years of age. Data suggest that higher income, higher education, and larger, suburban settings are associated with relatively better self-reported health status. Data also show that African-American respondents reported their health status as relatively lower than did Whites.

**Physical activity.** The “average” respondent participates in some form of physical activity 2-3 times/week. One-third participate 1 time per week or less. 63.1% of all respondents reported participating in some form of physical activity 2-3 times per week or less. Higher education was the only variable significantly correlated with activity level, suggesting that the data is fairly consistent across socioeconomic categories. No significant differences were found in the means of the two-group recode variables. There were similar averages between respondents 65 or older and 64 or younger, with the older cohort actually reporting a higher average activity level. Of those who are “never” physically active or are only “1 time per week,” physical health was the largest barrier cited; followed by time, which was also found to be a substantial barrier in the literature review; and then “gets plenty of exercise working,” which was expressed in “other.” Raising the 2-3 times/week and less to 4+ times/week presents an opportunity for the campaign.

**Eating.** The “average” respondent rates him or herself as “usually” eating healthy meals or snacks, presenting a challenge in communicating the need for more healthful eating. There were no significant correlations in the age, education, and income variables. There was a significant difference between the ratings of Whites (3.99) and African Americans (3.5). The main barriers expressed by those eating healthily “almost never” and “not very often” were “takes too much time” and “don’t enjoy health foods.” This suggests an approach that promotes quick, tasty, healthy meals and snacks.

**Smoking.** 28.7% of respondents reported having smoked or used tobacco products in the last ten years. 18.6% of the sample currently smokes or uses tobacco products. The percentages of current smokers or users were similar between men and women but a higher percentage were under 65 as compared to over 65.

**Control.** Respondents in this sample, overall, feel that physical activity and healthy eating contribute substantially to preventing chronic disease. This is positive in that the overall attitude in the survey was that healthy behaviors can make a difference. Those with lower household income believed this relatively less.

## Recommendations

Respondents in this sample already generally believe that physical activity and healthy eating contribute substantially to preventing chronic disease. This suggests a campaign approach that builds on this belief by defining (in gain frames) the kinds and amounts of physical activity and healthy eating that can prevent – or minimize the effects of – chronic disease. This allows target market members to evaluate their eating and activity against what is necessary to have an impact on disease prevention. Of course, this must be done in a way that does not sap motivation of

those whose current habits and practices don't measure up to these standards – i.e., an approach that builds upon current routines with additional slow, steady steps that can be incorporated into already busy or set lives and routines. At least in terms of self-reports, physical activity presents a larger opportunity for change than healthy eating, in which respondents rate themselves higher.

### **Screening Behaviors**

This section summarizes and makes recommendations based on data in the section of *Screening*. These data tell us about how many have been screened or tested for diseases or conditions and for which ones; why did/didn't they get screened; and how they knew where to go to get screened.

### **Summary**

Two-thirds responded that their doctor had tested or recommended that they be tested for a disease or condition. One-third did not, which appears sizeable given the physician's central role in this. 10% more in the group 65 and older responded "yes" than in the group 64 and younger to the question whether their doctor had tested or recommended that they be tested, suggesting greater opportunity for change in the younger cohort. The primary reason for getting screened was "I experienced pain." Similarly, the primary reason for not getting screened was "I have not experienced pain." This is an important "finding" that should be addressed in the campaign. Being told to by their doctor was also identified as a key reason for getting screened, highlighting the central role of physicians in this campaign. The doctor plays the central role in convincing respondents to keep current with their screenings, but data also show that immediate family members, particularly spouses, can play a strong role as well. Self was also seen as primary by many in "convincing" to keep current on screenings.

### **Recommendations**

Data show that, for one third of the sample, doctors can play a stronger role than they currently are in talking to their patients about screenings. The campaign can address this directly with physician partners or urge the target market (especially the younger cohort) to talk to their physician about screenings. The latter should be communicated in a positive way that places physicians in a positive light - after all, according to the survey, two-thirds are talking to their patients about screenings. Campaign messages can also capitalize on the strong role that spouses, especially, but also children can play in pressuring target market members to stay current with screenings. Data are clear in showing that campaign screening messages need to stress, Don't wait for symptoms! Loss frames stressing the costs of waiting should be used.

### **Physician Utilization**

This section summarizes and makes recommendations based on data in the section of *Doctor visits*. These data tell us how often and for what our target audience goes to the doctor.

## **Summary**

The overall average number of visits per year to a physician was 3.4 and the mode was 1, selected by 29% of respondents. 23% responded “2.” Income was not a substantial factor in this survey in determining frequency of visits to physicians. The main purpose given for visits was “physical exam or yearly check-up,” followed by “refilling a medication” and “treating a chronic condition.”

## **Recommendations**

Data show that 7.2% reported not visiting their doctor in a 12-month time period. 1 time was the mode (28.6%) followed by 2 times (22.5%). The main reason for visits was physical exam or yearly check-up. Given that half saw their doctor once or twice a year, these visits should include a screening inventory, and promoting this directly to physicians or through the target market may present an effective campaign tactic.

## **Chronic Disease Experience**

This section summarizes and makes recommendations based on data in the section of *Chronic Disease*. This section tells us how many in the survey have been diagnosed with a chronic disease; how they found out; whether they have received treatment; whether they believe they know how to manage their disease; and its impact on their daily activities. Data also shed light on how susceptible to chronic disease those who have not been diagnosed believe they are.

## **Summary**

60% of respondents reported having been diagnosed with a chronic disease. Of those who reported not having a chronic disease (average age 58.2), the “average” respondent felt that he or she was “somewhat likely” to “somewhat unlikely” to develop a chronic disease in the next 10 years. This may be optimistic given the average respondent was 58 and the question included the next 10 years. Most of those with chronic disease learned of it through a doctor’s visit. The vast majority received treatment for it. 7% did not. 96% said they know how to manage their chronic disease, which raises the question of how many see healthy eating and exercise behaviors as a part of this management. Over a third of respondents are caring for members in their household or relatives with chronic disease.

## **Recommendations**

40% of the sample did not have a chronic disease. Responses about the likelihood of developing a chronic disease get at the perceived susceptibility of these respondents. The campaign should communicate the real risk of developing chronic disease for people 45 to 65.

## **Sources (including media) and Credibility**

This section summarizes and makes recommendations based on data in the sections of *Sources* and *Credibility*. These data show which sources and media channels are used and preferred and which are seen as more credible.

### **Summary**

The doctor was identified first with 44%, followed by television (9.9%), the Internet (9.7%), and newspapers (7.6%) as primary sources for obtaining health information. In order of number of responses, television, newspapers, websites, and pamphlets were identified as primary media or channels of health information. Doctor's offices, pharmacies, and churches were identified as primary public places where posted health information is reviewed.

"Doctor" was rated highest in credibility, followed by MDHSS, relatives and family, and the Internet. Age was inversely correlated with perceived credibility of media of all types, meaning older respondents felt these media were less credible than did younger respondents. The same applied for size of community, with respondents in small, rural settings rating media as less credible than those in larger, urban settings. Higher income and education were significantly associated with higher credibility ratings for magazines. Income was also positively correlated with perceived credibility of the Internet. Income was inversely correlated with perceived credibility of relatives and family, possibly suggesting a stronger role for family and relatives in influencing targeted individuals in lower income categories. Older respondents also viewed local celebrities and politicians/public figures as significantly less credible than did younger respondents. Education was inversely correlated with perceived credibility of local celebrities. Non-Whites rated credibility of local celebrities significantly higher than did Whites.

### **Recommendations**

Data support the central role of the physician as a source of health information. Primary media channels should include television and newspapers. A website would be useful as a resource that target market members can access at their convenience and get detailed information. Data show it would probably be used more by those with higher income and education. Pamphlets and posters at doctors' offices, pharmacies, and churches are supported. Local celebrities may not be supported as spokesperson, though this of course depends on the celebrity and how wide is his or her appeal across sociodemographic groups.